Exhibit E
Additional Provisions

Attachment 1

Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

1. **Administrative Costs** means only those costs which arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services which would ordinarily be incurred in the provision of these services whether or not through a plan.

2. **Affiliate** means an organization or person that directly or indirectly through one or more intermediaries controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

3. **AIDS Beneficiary** means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.

4. **Allied Health Personnel** means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.

5. **Ambulatory Care** means the type of health services that are provided on an outpatient basis.

6. **Beneficiary Assignment** means the act of Department of Health Services (DHS) or DHS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHS or DHS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, provision 2.

7. **Beneficiary Identification Card (BIC)** means a permanent plastic card issued by the State to Medi-Cal recipients which is used by Contractors and providers to verify Medi-Cal eligibility and health plan enrollment.

8. **California Children Services (CCS)** means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

9. **California Children Services (CCS) Eligible Conditions** means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41800.

10. **California Children Services (CCS) Program** means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

11. **Catastrophic Coverage Limitation** means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

12. **Claims and Eligibility Real-Time System (CERTS)** means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

13. **Comprehensive Medical Case Management Services** means services provided by a Primary Care Provider to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

14. **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

15. **Contract** means this written agreement between DHS and the Contractor.

16. **Contracting Providers** means a Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

17. **Corrective Actions** means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.

18. **Cost Avoid** means Contractor requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.

19. **County Department** means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

20. **Covered Services** means Medical Case Management and those services set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with

Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

A. Services for major organ transplants as specified in Exhibit A, Attachment 11, provision 17.

B. Long term care services as specified in Exhibit A, Attachment 11, provision 17.

C. Home and Community Based Services (HCBS) as specified in Exhibit A, Attachment 11, provision 17 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an EPSDT service, including EPSDT supplemental services, as described in Title 22, CCR, Sections 51184, 51340 and 51340.1. EPSDT supplemental services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services.*

D. California Children Services (CCS) as specified in Exhibit A, Attachment 11, provision 8.

E. Mental health services as specified in Exhibit A, Attachment 10, provision 7.

F. Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider.

G. Alcohol and substance abuse treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, provision 6.

H. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, provision 7.

I. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, provision 15.

J. Dental services as specified in Title 22, CCR, Section 51307 and EPSDT supplemental dental services as described in Title 22, CCR, Section 51340.1(a). *However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, provision 14 regarding dental services.*

K. Acupuncture services as specified in Title 22, CCR, Section 51308.5.

L. Chiropractic services as specified in Title 22, CCR, Section 51308.

M. Prayer or spiritual healing as specified in Title 22, CCR, Section 51312.

N. Local Education Agency (LEA) assessment services as specified in Title 22, CCR, Section 51360(b) provided to a Member who qualifies for LEA services based on Title 22, CCR, Section 51190.1.

O. Any LEA services as specified in Title 22, CCR, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22, CCR, Section 51360.

P. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHS.

Q. Adult Day Health Care.

R. Targeted case management services as specified in Title 22, CCR, Sections 51185(h) and 51351, and as described in Exhibit A, Attachment 11, provision 2.

S. Childhood lead poisoning case management provided by County health departments.

T. Psychotherapeutic drugs listed in Exhibit A, Attachment 10-A (consisting of one page), and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997.

U. Human Immunodeficiency Virus (HIV) and AIDS drugs listed in Exhibit A, Attachment 10-B (consisting of one page), and HIV/AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, and any future new category of drugs for the treatment of HIV and AIDS, not previously classified (i.e. Fusion Inhibitors) approved by the federal Food and Drug Administration (FDA) after July 1, 1997.

21. **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

22. **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicaid program.

23. **Department of Health Services (DHS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in

California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

24. **Department of Managed Health Care (DMHC)** means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

25. **Department of Mental Health (DMH)** means the State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.

26. **Diagnosis of AIDS** means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

27. **Dietitian/Nutritionist** means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

28. **Director** means the Director of the State of California Department of Health Services.

29. **Disproportionate Share Hospital (DSH)** means a health Facility licensed pursuant to Chapter 2, Division 2, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to W&I Code, Section 14105.98.

30. **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes:

CalWORKs/Public Assistance Family - aid codes 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 47, 4F, 4G, 4M, 54, 59, 5X, 72, 7X, 8P;
Medically Needy Family – aid code 34;
Public Assistance Aged – aid codes 1H, 10, 14, 16, 18;
Medically Needy Aged – aid code 14;
Public Assistance Blind – aid codes 20, 26, 28;
Medically Needy Blind – aid code 24;
Public Assistance Disabled – aid codes 36, 60, 66, 68, 6A, 6C, 6H, 6N, 6P, 6R, 6V;
Medically Needy Disabled – aid code 64;
Medically Indigent Child – 03, 04, 4A, 4C, 4K, 45, 5K, 7A, 7J, 82, 8R;

Medically Indigent Adult – aid code 86; and
Refugees – aid Codes 01, 0A, 02, and 08, with the following exclusions:

A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.

B. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, and the Model Waiver Program.

C. Individual determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility for 30 days past the month of admission.

D. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and DHS has agreed, as a term of the HMO's contract, that these individuals may be enrolled. Individuals with Medicare fee-for-service coverage are not excluded from enrolling under this Contract.

31. **Emergency Medical Condition** means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

B. Serious impairment to bodily function, or

C. Serious dysfunction of any bodily organ or part.

32. **Emergency Services** means those health services needed to evaluate or stabilize an Emergency Medical Condition.

33. **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in the health plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

34. **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

35. **External Accountability Set (EAS)** means a set of HEDIS® and DHS-developed performance measures selected by DHS for evaluation of health plan performance.

36. **External Quality Review Organization (EQRO)** means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans.

37. **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract or
B. Maintained by a provider to provide services on behalf of the Contractor.

38. **Federal Financial Participation** means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

39. **Federally Qualified Health Center (FQHC)** means an entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396(l)(2)(B)).

40. **Federally Qualified Health Maintenance Organization (HMO)** means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC S300e).

41. **Fee-For-Service (FFS)** means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

42. **Fee-For-Service Medi-Cal** means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under this Contract.

43. **Fee-For-Service Medi-Cal Mental Health Services (FFS/MC)** means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

44. **Financial Performance Guarantee** means cash or cash equivalents which are immediately redeemable upon demand by DHS, in an amount determined by DHS, which shall not be less than one full month's capitation.

45. **Financial Statements** means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

46. **Fiscal Year (FY)** means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the federal Fiscal Year is October 1 through September 30.

47. **Health Maintenance Organization (HMO)** means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

48. **Health Plan Employer Data and Information Set (HEDIS®)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

49. **HEDIS® Compliance Audit** means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

50. **Indian Health Service (IHS) Facilities** means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area. (See Title 22, Section 55000.)

51. **Intermediate Care Facility (ICF)** means a Facility which is licensed as an ICF by DHS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22, CCR, Section 51212 and has been certified by DHS for participation in the Medi-Cal program.

52. **Joint Commission on the Accreditation of Health Care Organizations (JCAHO)** means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

53. **Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health & Safety Code.

54. **Marketing** means any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any

similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

55. **Marketing Representative** means a person who is engaged in marketing activities on behalf of the Contractor.

56. **Medi-Cal Eligibility Data System (MEDS)** means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

57. **Medical Records** means written documentary evidence of treatments rendered to plan Members.

58. **Medically Necessary** or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the medical necessity of health care services for a Medi-Cal beneficiary under the age of 21, the term “medically necessary” is expanded to include all services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a health care practitioner operating within the scope of his or her practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, physician or another provider of services.

59. **Member** means any Eligible Beneficiary who has enrolled in the Contractor's plan.

60. **Member Grievance** means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Member. DHS considers complaints and appeals the same as a grievance.

61. **Minimum Performance Level** refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

62. **Minor Consent Services** means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

A. Sexual assault, including rape.

B. Drug or alcohol abuse for children 12 years of age or older.

C. Pregnancy.

D. Family planning.

E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

G. Abortion.

63. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

64. **NCQA Licensed Audit Organization** is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

65. **Newborn Child** means a child born to a Member during her membership or the month prior to her membership.

66. **Non-Emergency Medical Transportation** means inclusion of services outlined in Title 22, CCR, Sections 51231.1 and 51231.2 rendered by licensed providers.

67. **Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations.

68. **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

69. **Not Reported** means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

70. **Nurse** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

71. **Other Healthcare Coverage Sources** (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member.

Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

72. **Outpatient Care** means treatment provided to a Member who is not confined in a health care Facility.

73. **Pediatric Subacute Care** means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.

74. **Physician** means a person duly licensed as a Physician by the Medical Board of California.

75. **Physician Incentive Plan** means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

76. **Policy Letter** means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division. This document will be utilized to notify the Contractor of clarifications made to the Medi-Cal Managed Care Program. This document will include instructions to the Contractor regarding implementation of mandated changes in regulations, statutes or judicial interpretation. This document will also be used to initiate various ongoing changes required of the Contractor throughout the Contract, the performance of which falls within the Contract’s agreed upon capitated rate.

77. **Post-Payment Recovery** means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

78. **Preventive Care** means health care designed to prevent disease and /or its consequences.

79. **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

80. **Primary Care Physician (PCP)** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The medical home is where care is accessible,

continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

81. **Primary Care Provider** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

82. **Prior Authorization** means a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

83. **Provider Grievance** means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Provider. DHS considers complaints and appeals the same as a grievance.

84. **Quality Improvement (QI)** means the result of an effective Quality Improvement System.

85. **Quality Improvement Projects (QIPs**) means studies selected by Medi-Cal Managed Care Plans, either independently or in collaboration with DHS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a twenty-four (24) month time frame.

86. **Quality Improvement System (QIS)** means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and Contract language. Contractor must have processes in place which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

87. **Quality of Care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

88. **Quality Indicators** means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

89. **Rural Health Clinic (RHC)** means an entity defined in Title 22, CCR, Section 51115.5.

90. **Safety-Net Provider** means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to

the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and Indian Health Service Facilities; disproportionate share hospitals; and, public, university, rural, and children's hospitals.

91. **Service Area** means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by DHS to operate under the terms of this Contract.

92. **Service Location** means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

93. **Skilled Nursing Facility (SNF)** means, as defined in Title 22, CCR, Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing Facility".

94. **Specialty Mental Health Provider** means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program.

95. **Specialty Mental Health Service** means:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

B. Psychiatric inpatient hospital services;

C. Targeted Case Management;

D. Psychiatrist services;

E. Psychologist services; and,

F. EPSDT supplemental specialty mental health services.

96. **State** means the State of California.

97. **Subacute Care** means, as defined in Title 22, CCR, Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

98. **Subcontract** means a written agreement entered into by the Contractor with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHS under the terms of this Contract.

99. **Sub-Subcontractor** means any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

100. **Supplemental Security Income (SSI)** means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

101. **Targeted Case Management (TCM)** means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

102. **Third Party Tort Liability (TPTL)** means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

103. **Traditional Provider** means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

104. **Urgent Care** means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

105. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

106. **Vaccines for Children (VFC) Program** means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating providers. Providers subcontracting with the Contractor are eligible to participate in this program.